Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2010 Session

Prepared by Staff for the
North Carolina Study Commission on Aging

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Commission on Children With Special Needs - Dentist

S.L. 2010-12 (HB 1694) adds a member to the Commission on Children with Special Health Care Needs. This additional member will be recommended by the North Carolina Dental Society, appointed by the Governor, and must be a licensed dentist who provides services to children with special needs.

This act became effective June 23, 2010. (TM)

Report on DHHS Position Eliminations

S.L. 2010-31, Sec. 10.5A (SB 897, Sec. 10.5A) allows the Secretary of the Department of Health and Human Services to achieve greater savings by adjusting the position reductions prescribed in the Joint Conference Committee Report. On or before March 1, 2011, the Secretary is required to report on position reductions to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report must include the number of positions, both vacant and filled, that are eliminated for the 2010-11 fiscal year and the savings generated by the elimination.

This section became effective July 1, 2010. (TM)

State-County Special Assistance Consolidating Changes

S.L. 2010-31, Sec. 10.19A (SB 897, Sec. 10.19A) changes references in the law from "State-county special assistance for adults" to "State-county special assistance." Assistance may be granted to any person who is 65 years of age and older, to any person between the ages of 18 and 65 who is permanently and totally disabled, and to any person who is legally blind according to definitions of a blind person under North Carolina laws governing aid to the blind.

This section became effective July 1, 2010. (TM)

Medicaid Fraud Prevention

S.L. 2010-31, Sec. 10.26 (SB 897, Sec. 10.26) authorizes the Department of Health and Human Services (Department) to create a fraud prevention program that uses information, lawfully obtained from State and private databases, to develop a fraud risk analysis of Medicaid providers and recipients. This information must be privileged and confidential, is not a public record pursuant to G.S. 132-1, and may be used only for investigative or evidentiary purposes related to violations of State or federal law and regulatory activities. All records and information obtained pursuant to this section must be destroyed after five years, unless there has been criminal, civil, or administrative action involving the records and information obtained.

The section authorizes the Department to modify or extend existing contracts to achieve Medicaid fraud prevention savings in a timely manner, subject to review and approval by the Secretary of the Department of Administration.

This section became effective July 1, 2010. (SP)

Medicaid Recipient Appeals Process

S.L. 2010-31, Sec. 10.30 (SB 897, Sec. 10.30) creates a new Part 6A in Article 22 of Chapter 108A of the General Statutes to govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department of Health and Human Services (Department). For recipients who have been denied, terminated, suspended, or reduced

benefits, the section directs the Department to notify the recipient at least 10 days before the adverse determination is effective and to inform the recipient of the right to appeal the adverse determination. The recipient has 30 days to appeal and, if appealed, the appeal is a contested case to be heard by an administrative law judge. Prior to the hearing before the administrative law judge, mediation must be offered to the recipient. If mediation is successful, the mediator must inform the Department and the Office of Administrative Hearings (OAH) and the administrative law judge must dismiss the case. If mediation is unsuccessful, the administrative law judge must hear the case and make a determination. The burden of proof in the hearing is the on recipient to show entitlement to a requested benefit or propriety of a requested action, and it is on the Department if the adverse determination being appealed is imposing a penalty or is reducing, terminating, or suspending a benefit previously granted. The final agency decision must be made within 20 days of the receipt of the administrative law judge's decision.

The section directs the Department and OAH to report to the House and Senate Appropriations Subcommittees on Health and Human Services; the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services; and the Fiscal Research Division, on the number, status, and outcome of contested Medicaid cases handled by OAH pursuant to the appeals process established in Part 6A of Article 2 of Chapter 108A of the General Statutes. The report must include information on the number of contested Medicaid cases resolved through mediations and through formal hearings, the outcome of settled and withdrawn cases, and the number of incidences in which the Division of Medical Assistance (DMA) reverses the decision of an administrative law judge, along with DMA's rationale for the reversal. The report must be submitted not later than October 1, 2011.

This section became effective July 1, 2010. (SP)

Medicaid Changes

S.L. 2010-31, Sec. 10.35 (SB 897, Sec. 10.35) amends Sec. 10.68A of S.L. 2009-451, as amended by Sec. 5A of S.L. 2009-575, by making changes primarily to the following services: In-Home Care, Personal Care Services, Mental Health Residential Services, and Private Duty Nursing.

In-Home Care - The later of January 1, 2011, or approval by the Centers for Medicare and Medicaid Services (CMS) for elimination and replacement of Personal Care Services (PCS) and PCS-Plus, the Department of Health and Human Services, Division of Medical Assistance (DMA) will implement the provisions below.

- Replace PCS and PCS-Plus with the two new services listed below and provide a Medical Coverage Policy for each.
  - **In-Home Care for Children (IHCC)** which will provide families with services to help meet in-home care needs of children, including individuals under the age of 21 that are receiving comprehensive and preventive child health services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In accordance with existing law establishing procedures for changing medical policy (G.S. 108A-54.2), an individual may qualify for up to 60 hours per month based on an assessment conducted by DMA, or designee, and a plan of care developed by the service provider and approved by DMA, or designee. Additional hours may be authorized under certain conditions.
  - **In-Home Care for Adults (IHCA)** which will provide services to assist with the following activities of daily living (ADLs) eating, dressing, bathing, toileting, and mobility for individuals 21 years of age or older who because of a medical condition, disability, or cognitive impairment, demonstrate unmet needs for a minimum of: (i) three of the five qualifying ADLs with limited hands-on assistance; (ii) two ADLs, one of which requires extensive assistance; or (iii) two ADLs, one of which requires assistance at the full dependence level. IHCA will serve individuals at the highest level of need for in-home care and who are able to remain safely in the home. Up to 80 hours of services may be provided per

month with an assessment conducted by DMA, or designee, and a plan of care developed by the service provider and approved by DMA, or designee.

- Implement the limitations and restrictions below for IHCC and ICHA.
  - Services required by EPSDT must be provided to qualified recipients in the IHCC program.
  - Provided services must supplement, rather than supplant family roles and responsibilities.
  - Authorized services must be based on a needs assessment and must take into account care and services provided by family, public and private agencies, and informal caregivers. Available resources must be disclosed to the DMA assessor.
  - Services must be related to hands-on assistance or tasks to complete each qualifying ADL in accordance with the IHCC or IHCA assessment and plan of care.
  - Household chores not directly related to the qualifying ADLs, nonmedical transportation, financial management, and non-hands-on assistance (cueing, prompting, guiding, coaching, or babysitting) are not included under IHCC and IHCA.
  - Essential errands necessary for the health and welfare of the recipient may be approved on a case-by-case basis by the DMA assessor when there is no family member, other individual, program or service available to meet the need.
- Admission process for IHCC and ICHA:
  - Recipient must be seen by primary or attending physician who is required to provide written authorization and referral for the service and written attestation to the medical necessity for the service.
  - DMA, or designee, performs assessments for admission, continuation of services, and change of status reviews. (The designee may not be an owner of a provider business, or provider of in-home or personal care services of any type.)
  - DMA, or designee, determines the recipient's degree of functional disability and level of unmet needs for hands-on personal assistance in the five qualifying ADLs and determines and authorizes the amount of service to be provided on a "needs basis".
- Take action to manage cost, quality, program compliance, and utilization of services provided under IHCC and IHCA including, but not limited to the following:
  - Priority independent reassessment of recipients before the anniversary date of their initial admission or reassessment of recipients likely to qualify for IHCC and IHCA programs.
  - Priority independent reassessment of recipients requesting a change of service provider.
  - Targeted reassessments of recipients prior to anniversary dates when the current provider assessment indicates they may not qualify for the program or for the amount of services currently being received.
  - Targeted reassessment of recipients receiving services from providers with a history of program noncompliance.
  - On-site reviews and recoupment of all identified overpayments or improper payments.
  - Recipient reviews, interviews, and surveys.
  - Mandated electronic transmission of referral forms, plans of care, reporting forms, and of uniform reporting forms for recipient complaints and critical incidents.
  - Use of automated systems to monitor, evaluate, and profile provider performance against established performance indicators.
  - Establish rules to implement requirements for home health agency surety bonds (42 C.F.R. Section 441.16).
- Timeline for Implementation if IHCC and IHCA.

- Subject to the approval of the programs by CMS, the Division of Medical Assistance must make every effort to implement IHCC and IHCA by January 1, 2011.
- The Division must ensure that individuals qualified for IHCC and IHCA do not have a lapse in service. When an independent reassessment has not been performed and the current assessment documents that the medical necessity requirements for IHCC or IHCA have been met, then an individual must be admitted on the basis of their current provider assessment.
- In accordance with federal hearing requirements (42 C.F.R. Section 431.220(b)), prior to implementation of IHCC and IHCA, recipients in the PCS and PCS-Plus programs must be notified and discharged and these programs will terminate. However, recipients qualifying for IHCC and IHCA must be admitted and eligible to receive services immediately.

Personal Care Services

- DHHS is required to conduct a study to determine the cost effectiveness, efficiencies gained, and challenges of transitioning the performance of independent assessments to Community Care of North Carolina for PCS, IHCC, or IHCA services. On or before January 1, 2011, the Department must report findings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.
- The Division of Medical Assistance (DMA) is required to study the incidence of fraud, waste, or abuse by Medicaid PCS providers and recipients and by Medicaid IHCC or IHCA providers and recipients. On or after January 1, 2011, and annually thereafter, the Division must report findings to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Mental Health Services

- The Department is required to study the effectiveness of the length of stay limitation and the number of children staying in Level II, II, and IV facilities. The Department must report findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before January 1, 2011 and provide update reports every six months for a three-year period on the number of children in these facilities.
- Following the sixteenth visit, the DMA must require prior authorization for outpatient mental health services for children.

Private Duty Nursing

- The DMA must change Medicaid Private Duty Nursing (PDN) by restructuring the program to as follows:
  - Services provided only to qualified recipients under the age of 21.
  - Services must be authorized by the recipient's primary care or attending physician.
  - Services must be limited to 16 hours per day, unless additional services are required to correct or ameliorate defects and physical and mental illnesses and conditions defined by federal law (42 U.S.C. Section 1396d(r)(5).)
  - Services are based on an initial assessment and continuing need reassessments performed by an Independent Assessment Entity that does not provide PDN services and authorized in amounts that are medically necessary based on the recipient's medical condition, amount of family assistance, and other relevant conditions.
  - Services must be provided in accordance with a plan of care approved by DMA or designee.
  - A Home and Community Based Services Waiver for individuals dependent on technology to substitute for a vital body function must be developed and submitted to CMS.

- Transition qualified recipients age 21 and older and currently receiving PDN to waiver services provided under the Technology Dependent Waiver upon approval by CMS and the Medicaid Clinical Coverage Policy.

This section became effective July 1, 2010. (TM)

Medicaid Waiver for Assisted Living

S.L. 2010-31, Sec. 10.35A (SB 897, Sec. 10.35A) requires the Division of Medical Assistance, DHHS, to develop and implement either a Home and Community Based Services assisted living program or an Assisted Living Services program under the State Medicaid Plan in an effort to continue Medicaid funding of PCS to individuals living in adult care homes. The division must determine which program to implement based on analysis of which alternative best addresses resident needs and federal requirements. The Division is required to apply for program approval to the Centers for Medicare and Medicaid Services by August 10, 2010. By January 1, 2011, the Division must report on the program to the Joint Legislative Commission on Governmental Operations, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division

This section became effective July 1, 2010. (TM)

Project C.A.R.E. (Caregiver Alternatives to Running On Empty)

S.L. 2010-31, Sec. 10.35B (SB 897, Sec. 10.35B) directs the Division of Aging and Adult Services, Department of Health and Human Services, to annually develop and implement a plan for Project C.A.R.E. (Caregiver Alternatives to Running on Empty). Beginning October 1, 2010, and annually thereafter, the Division must report to the Governor's Advisory Council on Aging, the North Carolina Study Commission on Aging, and the Fiscal Research Division.

This act became effective July 1, 2010. (TM)

Update Long-Term Care Statutes

S.L. 2010-66 (HB 1698) amends inconsistent and antiquated statutory language and incorporates references to "long-term services and supports" and "person-centered services" as current programs and services. The amendments also incorporate the use of "Community Resource Connections for Aging and Disabilities," which is the name North Carolina has adopted for their aging and disability resource centers.

This act became effective July 8, 2010. (TM)

Implement Long-Term Care Partnership Program

S.L. 2010-68 (SB 1193) establishes the North Carolina Long-Term Care Partnership Program (Program) to be administered by the Division of Medical Assistance, Department of Health and Human Services, with assistance from the Department of Insurance. The Program allows an individual who applies for long-term care Medicaid and who has a qualified long-term care partnership policy ("qualified policy") to protect a portion of the individual's assets from consideration for the purposes of:

- determining eligibility for enrollment into long-term care Medicaid (resource disregard), and
- estate recovery actions for payment of care provided to the enrollee, once they are deceased (resource protection).

The amount protected under both resource disregard and resource protection will be equal to the dollar amount of benefits actually paid to or on behalf of the individual under the qualified policy from the date the qualified policy was issued to the date the individual applied for long-term care Medicaid.

In order to be considered a qualified long-term care partnership policy, the following must apply:

- The policy meets multiple federal requirements.
- The policy is issued on or after the effective date of the Act.
- The policy covers an insured individual that is a resident of North Carolina, or a state with a reciprocal partnership program.
- The policy includes specified inflation protection coverage.
- The policy includes specified disclosure notices to the policy holder or insured regarding the application of resource disregard and resource protection.

Additionally, the act:

- Authorizes the Department of Health and Human Services to adopt rules and amendments to the Medicaid State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery.
- Authorizes the Department of Health and Human Services to enter into reciprocal agreements with other states that enter into a national reciprocity agreement to extend the resource disregard and resource protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.
- Authorizes the Department of Insurance to adopt rules conforming State long-term care policies and certificates to the requirements of federal law and regulations and to adopt rules to provide for implementation and administration of the Partnership Program.
- Requires insurers to provide policy holders with certain disclosure notices relating to loss of qualified policy status.
- Provides that within 180 days of the date when an insurance company starts to offer qualified policies, the insurer must offer to holders of existing long-term care insurance policies issued on or after February 8, 2006, a onetime offer to exchange the existing policy for a qualified policy. A qualified policy issued as a result of this exchange is to be treated as newly issued and is eligible for qualified policy status.
- Allows the Commissioner to share "identifying information" related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the partnership program.

This act becomes effective the later of January 1, 2011, or 60 days after the approval of the Medicaid State Plan amendment. (TM)

Continuing Care Retirement Community/Home Care

S.L. 2010-128, Sec. 1-4 (SB 354, Sec. 1-4) amends the law on Continuing Care Retirement Communities (CCRC) to allow the provision or arrangement of home care services to an individual who has entered into a continuing care contract with a provider but is not yet receiving lodging with the provider. A contract to provide continuing care without lodging must specify the procedures for determining when the individual will transition to receiving both lodging and health-related services.

A CCRC that wishes to provide or arrange for the provision of continuing care services without lodging must submit the following to the Department of Insurance:

- An application to offer continuing care services without lodging.
- An amended disclosure statement with the type and a description of the services that will be provided without lodging, the target market, and the fees to be charged.

- A copy of the written service agreement containing those provisions as prescribed in current law.
- A summary of an actuarial report that presents the impact of providing continuing care services without lodging on the overall operation of the CCRC.
- A financial feasibility study prepared by a certified public accountant showing the financial impact of providing continuing care services without lodging on the applicant and the continuing care retirement facility or facilities. The study must include a statement of activities reporting the revenue and expense details for providing continuing care services without lodging, as well as, any impact the provision of these services will have on operating reserves.
- Evidence of a license to provide home care services, or a contract with a licensed home care agency for the provision of home care services, to those individuals under the continuing care services without lodging program.

Additionally, the act increases from $500 to $1000, the application fee for a continuing care license.

This act became effective July 21, 2010, the fee increase also became effective July 21, 2010 and applies to applications filed on or after that date.

See **Studies** in this Chapter for a summary of Section 5 of this act. (TM)

Prohibit Medicaid Fraud – Kickbacks

S.L. 2010-185 (SB 675) makes it a Class I felony to knowingly and willfully solicit or receive remuneration including kickbacks, bribes , or rebates in return for or to induce a person to:

- Refer an individual to a person for the furnishing, or arranging of the furnishing, of an item or service paid for in whole or in part with Medicaid funds.
- Purchase, lease, order, arrange for, or recommend the purchase, lease, or order of any good, facility, service, or item paid for in whole or in part with Medicaid funds.

The act exempts contracts between the State and public or private agencies that have the responsibility to refer persons to Medicaid providers and exempts certain conduct and activity deemed acceptable by the federal Government.

This act becomes effective December 1, 2010. (SP)

Studies

Referrals to Departments, Agencies, Etc.

Study Medicaid Provider Rates

S.L. 2010-31, Sec. 10.25 (SB 897, Sec. 10.25) directs the Department of Health and Human Services (Department) to study or contract out for a study of reimbursement rates for Medicaid providers and program benefits. The study must include:

- A comparison of Medicaid reimbursement rates in North Carolina with reimbursement rates in surrounding states and with rates in two additional states.
- A comparison of Medicaid program benefits in North Carolina with program benefits provided in surrounding states and with rates in two additional states. Selected provider rates must be studied for the initial report.

The section directs the Department to report its initial findings to the Governor, the Senate Appropriations Committee on Health and Human Services, the House of Representatives

Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division by April 1, 2011.

This section became effective July 1, 2010. (SP)

Nurse Aide Training Review

S.L. 2010-69 (SB 1191) directs the Division of Health Service Regulation, Department of Health and Human Services (DHHS), to coordinate an evaluation of the education and training requirements for nurse aides. While conducting the evaluation, the Division must include an equal number of representatives from the following entities:

- Division of Health Service Regulation, DHHS.
- Division of Aging and Adult Services, DHHS.
- North Carolina Board of Nursing.
- North Carolina Community College System.
- Direct Care Workers Association of North Carolina.
- North Carolina Medical Society.
- North Carolina Health Care Facilities Association.
- North Carolina Hospital Association.
- Association for Home and Hospice Care of North Carolina.
- North Carolina Assisted Living Association.
- North Carolina Association of Long Term Care Facilities.
- North Carolina Association of Non-Profit Homes for the Aging.
- Individuals representing residents in long-term care.

On or before November 1, 2010, the Division must report findings and recommendations regarding the appropriate levels of nurse aide education and training to the North Carolina Study Commission on Aging.

This act became effective July 8, 2010. (TM)

Medicaid Dental/Special Needs Population

S.L. 2010-88 (HB 1692) directs the Divisions of Medical Assistance and Public Health, Department of Health and Human Services, to study issues that would facilitate dental care and improved dental outcomes for individuals with special needs. The study must examine, but is not limited to:

- The feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidence-based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high-risk adults with special health care needs.
- The feasibility and anticipated impact of implementing facility code policies to allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of the service.

On or before November 15, 2011, the Department must report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission.

This act became effective July 11, 2010. (TM)

Adult Day Care Criminal Record Check Process

S.L. 2010-93 (HB 1703) requires the Division of Aging and Adult Services, Department of Health and Human Services, to study the issue of criminal history record checks for current and prospective owners, operators, and volunteers of adult day care programs and adult day health services programs. The study should include the following:

- Identifying the positions that warrant a criminal history record check.
- Developing a process for conducting the criminal history record check.
- Designating the entity responsible for requesting the criminal history record check.
- Designating the entity responsible for paying for the criminal history record check.
- Determining whether a State or a national criminal history record check, or both, is performed.
- Defining the relevant offenses that indicate an individual's fitness to have responsibility for the safety and well-being of program participants.
- Any other issues deemed appropriate.

On or before November 1, 2010, the Division is required to report findings and recommendations to the North Carolina Study Commission on Aging.

This act became effective July 11, 2010. (TM)

Continuing Care Retirement Community/Home Care

S.L. 2010-128, Sec. 5 (SB 354, Sec. 5) requires the Department of Insurance and the Department of Health and Human Services to identify statutory, regulatory, or practical barriers that prevent or discourage individuals that contract with continuing care retirement communities from receiving home care services. An interim report must be provided on or before November 1, 2010, and a final report on or before September 1, 2010, to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee.

This section became effective July 21, 2010.

See **Enacted Legislation** in this Chapter for a summary of Sections 1-4 of this act. (TM)

Joint Legislative Health Care Oversight Committee Studies

S.L. 2009-152, Part III (SB 900, Part III) authorizes the Joint Legislative Health Care Oversight Committee to study the following issues and report its findings with any recommended legislation to the 2011 Regular Session of the General Assembly upon its convening:

- The feasibility of establishing a State Diabetes Coordinator.
- A collaborative project for reducing medical malpractice costs and claims.
- The impact of revised eligibility requirements for Personal Care Services on seniors and disabled citizens.

This part became effective July 10, 2010. (SB)

New/Independent Studies/Commissions

Develop Special Needs Dental Care Workforce

S.L. 2010-92 (HB 1693) directs the North Carolina Area Health Education Centers (AHEC) Program to coordinate efforts to increase the number of dental care providers for individuals with special needs. Efforts must include, but are not limited to:

- Identifying opportunities to increase the dental care workforce available to treat individuals with special needs by working with the State's dental schools, the Community College System, and current dental providers serving individuals with special needs. These opportunities must include, but are not limited to, options that could be undertaken without additional funding.
- Working with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students to receive training in long-term care facilities under the direction of nonprofit special care dental organizations.

On or before August 1, 2011, the AHEC Program must report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission.

This act became effective July 11, 2010. (TM)

Consumer Guidelines for Hearing Aid Purchases

S.L. 2010-121 (HB 1705) requires the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force will include the following:

- A licensed practicing fitter and seller of hearing aids, recommended by NC Hearing Aid Dealers and Fitters Board.
- A consumer of hearing aids, recommended by the Division of Services for the Deaf and Hard of Hearing.
- A practicing audiologist, recommended by the NC Board of Examiners for Speech and Language Pathologists and Audiologists.
- A physician who treats patients with hearing loss, recommended by the NC Medical Board.
- A representative of the Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services.
- A representative of the Consumer Protection Division, recommended by the Office of Attorney General.
- Other interested stakeholders.

On or before November 15, 2010, the Board is required to report findings and recommendations, including methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging.

This act became effective July 20, 2010. (TM)

Legislative Research Commission

Require Long-Term Care Facilities to Carry Liability Insurance

S.L. 2010-152, Sec. 2.14 (SB 900, Sec. 2.14) permits the Legislative Research Commission to study whether long-term care facilities should be required to carry liability insurance. The study should consider the following:

- Whether State law adequately protects the ability to receive just compensation if actions are taken to shield personal or business assets.
- Whether a long-term care facility should carry liability insurance as a condition of licensure.
- Whether other states require long-term care facilities to carry liability insurance as a requirement for licensure.

This act became effective July 22, 2010. (TM)